EMPLOYEE ERGONOMIC HISTORY

Date:	Time:	Employee:	Employee Badge Number:
Building/Office:	Phone Number:	E-mail Address:	
Job Title and Task Performed:		New Employee ☐ Yes ☐ No New Workstation ☐ Yes ☐ No Do you routinely experience discomfort or pain ☐ Yes ☐ No	

Please check all that apply:

Body Part	Left/Right	Severity of Pain or Discomfort[1]	Frequency of Pain or Discomfort[2]	Medical Treatment Received	Date First Noticed	Comments/Description (Describe Treatment Plan)
A. Hands/Wrists /Fingers	☐ L ☐ R	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
B. Elbows /Forearms	☐ L ☐ R	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
C. Shoulders	☐ L ☐ R	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
D. Legs	☐ L ☐ R	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
E. Neck		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
F. Upper Back		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
G. Lower Back		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
H. Headache /Eye Strain		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		
I. Other		☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ A ☐ B ☐ C	☐ Y ☐ N		

[1]Severity: 1 = Mild (noticeable discomfort less than two times per week for less than 30 minutes per event)
2 = Moderate (noticeable pain on a daily basis for less than 30 minutes)
3 = Severe (noticeable pain greater than two hours per day that subsides with over the counter medications)
4 = Unbearable (noticeable pain that debilitates or is continually present)

[2]Frequency: A = Seldom (one time per week)
B = Often (three to five times per week)
C = Always (daily)

J. Do you feel pain/discomfort is related to workstation setup or equipment? ☐ Yes ☐ No
a. If no, what do you feel is causing problem?

K. Previous injuries or treatment to problem area and pre-existing medical conditions (arthritis, diabetes, pregnancy, etc.):

L. Outside activities (Hobbies with a history of stress factors such as: softball/baseball, racket sports, bowling, cycling, golf, painting sanding, playing musical instruments, sewing/needlework, gardening, weightlifting, etc.):

M. Do you experience any pain due to these activities? ☐ Yes ☐ No

N. Do you have a home computer? ☐ Yes ☐ No Hours used per day on average:

O. Do you smoke? ☐ Yes ☐ No

P. Please provide additional information that may be relevant to your discomfort: